Birth History

Patient's First/Last Name: _____ Birthdate: _____

Age _____ Date _____

Birth Weight: _____ Birth Length: _____

Delivering Hospital: _____

Was the baby born at term? Yes or No If early, how many weeks? _____ If late, how many weeks? _____

Type of delivery? Vaginal or Cesarean If Cesarean, why? _____

Any problems with the baby's health after birth? Yes or No

If yes, please explain: _____

Type of feeding your baby has been getting? Breast Formula Both

Illnesses or problems with the mother's health during pregnancy? Yes or No

If yes, please explain: _____

_____

During the pregnancy, did Mother use tobacco products? Yes or No Consume alcohol? Yes or No

If yes, please explain: _____

Please list any maternal medications taken during pregnancy: _____

_____

Past Medical History

Patient's First/Last Name: _____ Birthdate _____

This form is necessary to provide the "complete picture" of your child's health to your provider. By gathering this information, it allows your provider to offer the best care possible for your child(ren).

Patient's Past Medical History—Please Print

1. Please list any previous hospitalizations? (list month/year, hospital and reason for hospitalization) □None

   _____

2. Please list any previous surgeries? (list month/year, hospital and surgery performed) □None

   _____

3. Please list any serious injuries or accidents? (list month/year and nature of injury/accident) □None

   _____

4. Any drug or food allergies? □Yes □No (if yes list below with reaction)

   _____

5. Does your child have any special communication needs? □Yes □No (If yes, please explain below)

   _____

6. Does your child see a dentist? ☐Yes ☐No If yes, who: _____ Date of last visit: _____

Please **CIRCLE** any condition your child currently has or has had in the past:

Chicken pox
If Yes When? _____

Eye conditions/corrective lenses
Frequent ear or sinus infections
Problems with ears or hearing
Frequent pharyngitis or tonsillitis
Allergic rhinitis or other allergy
Indoor allergens:_____
Outdoor allergens:_____
Asthma
Frequent bronchitis, bronchiolitis, or pneumonia
Recurrent Croup
Other chronic/serious lung disease
Tuberculosis or positive TB test
Congenital/acquired heart defect
Constipation requiring visits

Bladder, kidney infection or other urologic problem
Thyroid or other endocrine problem
Diabetes
Chronic or recurrent skin problem (acne, eczema, etc.)
Frequent headaches
Seizures or other neurologic problems
Developmental delay or disorder
Behavior disorder (ADHD, ODD, other)
Cancer
HIV/AIDS
Orthopedic problem
High Cholesterol
High blood pressure
Heart murmur
Anemia or bleeding problem

Please explain any conditions you circled above or any other significant medical problems:

_____

Family History

Patient's First/Last Name: _____ Birthdate _____

Family History—Check all that apply. ONLY include GENETIC family members.

(Leave blank if the child is a foster child, adopted, or if the biological parents are unknown.)

	Mom	Dad	Sister	Brother	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Cancer								
Asthma/Other Lung Disease								
Nasal/Other Allergies								
Diabetes or Other Endocrine Problems (before 50 years old)								
High Blood Pressure								
High Cholesterol								
Heart Disease (before 50 years old)								
Rheumatologic Disease (Arthritis, Lupus, Thyroid Disease)								
Kidney Disease								
Liver Disease								
Anemia								
Bleeding Disorder								
Developmental Delay/Disorder								
Mental Illness								
Epilepsy, Convulsions, or Seizures								
Neurologic Disorder								
ADHA/ADD								
Autism								
Alcohol Abuse								
Drug Abuse								
Hearing Problems/Deafness								
Vision Impairment/Eye Disorder (not including standard glasses or contacts)								
Tuberculosis								
Bed-wetting (after 10 years old)								
Immune Problems, Recurrent Infections, or HIV/AIDS								
Milk and/or Soy Intolerance								
Other GI Disease/Disorder								
Unexplained Sudden Death (before 50 years old)								

Additional Pertinent Conditions

Explain _____

_____

Social History

Patient's First/Last Name: _____ Birthdate _____

Social History—Please Print

List the name of those LIVING IN THE HOUSEHOLD- include any parents, siblings , any extended family, step-family, grandparents, others	**Date of Birth**	**Relationship to Child**

1. Parents' Marital Status: □Married □Divorced □Separated □Never Married □Other

_____

2. If parents are not living together or if the child does not live with parents, what is the child's custody status?

_____

3. What is the visitation status of any non-custodial parent(s)?

_____

4. Daytime Status: □Home □Daycare □School

5. Does anyone in the household smoke? □Yes □No

6. Does anyone at daycare smoke? □Yes □No □Not applicable

7. Are there pets in the home? □Yes □No

8. Are there pets in the daycare? □Yes □No □Not applicable

9. Are there firearms in the home? □Yes □No

10. Are the guns locked and kept separate from ammunition? □Yes □No □Not applicable

10. In the last year, have you worried that the food you purchased would run out before you had money to buy more? □Yes □No □Declined to Answer

11. In the last year, did you run out of food and not have money to purchase more?

□Yes □No □Declined to Answer

If you answered **yes to the two questions above**, would you like information on community resources that can help?

□Yes □No